DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE

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MINIMUM NECESSARY REQUIREMENTS FOR USING AND DISCLOSING PROTECTED HEALTH INFORMATION	**500.03**	**12/15/2003**	**1 of 4**
APPROVED BY:  Director	SUPERSEDES **500.7 12/15/2003**	ORIGINAL ISSUE DATE **04/14/2003**	DISTRIBUTION LEVEL(S) **1**

PURPOSE

1.1 To describe the application of the minimum necessary rule to uses, disclosures and requests for Protected Health Information (PHI).

POLICY

2.1 The Department of Mental Health (DMH) must make reasonable efforts to limit the use, disclosure of, and requests for PHI to the ***minimum necessary*** to accomplish the intended purpose of the use, disclosure or request.

2.2 The minimum necessary rule does not apply to:

2.2.1 Disclosures to or requests by a health care provider for treatment;

2.2.2 Uses or disclosures made to the client or his/her legal representative;

2.2.3 Uses or disclosures made pursuant to an authorization;

2.2.4 Uses and disclosures required by law; and

2.2.5 Uses and disclosures required by compliance with Heath Insurance Portability and Accountability Act (HIPAA) standardized transactions.

2.3 DMH may not use, disclose or request an entire medical record, except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure or request.

2.4 DMH must designate its employees who need access to PHI to carry out their duties **and** must designate the level of access needed and the conditions appropriate to such access.

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PROCEDURE

3.1 DMH must ensure that each facility/clinic supervisor completes and maintains a binder with the **HIPAA Minimum Necessary PHI Staff Access Form** (Attachment I) for each employee, student/intern and volunteer and the form shall be:

- Updated annually.
- Updated as needed based on changes in positions/roles.
- Updated upon termination and/or transfer of position (Termination Policy 601.03 and Transferred Policy 601.04).

3.2 DMH staff who are directly involved in a client's treatment and care may have access to all of the client's PHI. DMH staff who are not directly involved in a client's treatment may not have unlimited access to a client's PHI. It is a violation of the minimum necessary rule for a health care provider to access the PHI of clients with whom the provider has no treatment relationship, unless for research purposes as permitted by the Privacy Regulations and these policies.

3.3 The access granted to student/interns must be determined on a case-by-case circumstance depending on the educational activity. A student's access must be determined by, and monitored by, the instructor.

4.1 **Disclosures**

4.1.1 Routine Disclosures DMH should implement standard protocols, when appropriate, to limit the PHI disclosed on a routine or recurring basis. Copies of such protocols should be forwarded to the DMH Privacy Officer.

4.1.2 Non-Routine Disclosures All non-routine disclosures (those that do not occur on a day-to-day basis as part of treatment, payment or health care operation activities or which are required by law on a regular basis) must

be reviewed by County Counsel. When considering non-routine disclosures, County Counsel should consider the following criteria:

4.1.2.1 the purpose of the request;

4.1.2.2 any potential harm that would result to the client, to DMH, or any other third party as a result of the disclosure;

4.1.2.3 the relevancy of the information requested; and

4.1.2.4 other applicable State and Federal laws and regulations.

4.1.3 DMH may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose when:

4.1.3.1 making disclosures to public officials as required by law, if the public official represents that the information requested is the minimum necessary for the stated purpose;

4.1.3.2 the information is requested by another covered entity;

4.1.3.3 the information is requested by a professional who is an employee of DMH or is a business associate providing professional services, if the professional or business associate represents that the information is the minimum necessary for the stated purpose; or

4.1.3.4 documentation submitted by a researcher that the information is preparatory to research, related to research on a decedent, or the disclosure has been approved by the Institutional Review Board (IRB).

5.1 **Requests**

5.1.1 Routine Requests DMH should implement standard protocols, when appropriate, to limit the PHI requested on a routine or recurring basis. Copies of such protocols should be forwarded to the DMH Privacy Officer.

5.1.2 Non-Routine Requests DMH must designate a person to be responsible for reviewing all non-routine requests (those that do not occur on a day-to-day basis as part of treatment, payment or health care operation activities). Any questions regarding the propriety of a particular request must be submitted to County Counsel. When considering non-routine disclosures, the following criteria must be considered:

5.1.2.1 the reason for the request;

5.1.2.2 any potential harm that would result to the client, DMH, or any other third party as a result of the request;

5.1.2.3 the relevancy of the information requested; and

5.1.2.4 other applicable State and Federal laws and regulations.

DOCUMENTATION RETENTION

6.1 All documents required to be created or completed under this policy and procedure will be retained for a period of at least six (6) years from the date of its creation and the date when it was last in effect, whichever is later.

AUTHORITY

HIPAA, 45 CFR Sections 164.502(a) and 164.514(b)

ATTACHMENTS

1. HIPAA Minimum Necessary PHI Staff Access Form